NORTHERN NEVADA ADULT MENTAL HEALTH
POLICY AND PROCEDURE DIRECTIVE

SUBJECT: CLOSED RECORD REVIEW PROCESS

NUMBER: NN-IM-MR-18

ORIGINAL DATE: 1/8/04

REVIEW/REVISE DATE: 1/4/07, 5/20/10

APPROVAL: Rosalyne Reynolds *{s}*, Agency Director

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I. PURPOSE

The purpose of this policy is to delineate a method for the closed record review process in order to assure that closed records are reviewed consistently for quality and completeness.

II. POLICY

It is the policy of Northern Nevada Adult Mental Health Services (NNAMHS) to perform closed record review monthly as a method of reviewing staff performance, referral systems and appropriateness of care. The purpose of this process is to insure continuous improvement by monitoring trends and using the data as a teaching tool.

III. DEFINITIONS

A. Closed Record Review: A review process in which deficiencies in consumer care are identified and corrective actions implemented.
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IV. REFERENCES

Joint Commission Comprehensive Manual for the Accreditation of Hospitals RC.01.04.01 The Hospital Audits Its Medical Records

NN-IM-MR-17: Incomplete/Delinquent Records Policy

V. PROCEDURES

A. NNAMHS completes two levels of closed record review. These are

1. Review of closed records for completeness and delinquency rate. This process is completed by Health Information Services staff.
2. Review of closed record documentation to assure that required documentation is not only complete but also reflective of the treatment process. This process is completed by a committee comprised of clinical staff.

B. The closed record review process is done at the beginning of each month. This process includes the identification of charts from the previous month for review by Health Information Services

1. Charts selected for review will meet the following criteria:

a. 20% of records closed during the month will be identified. The records will be selected in the following manner:

A. Inpatient Hospital 2
B. Galletti Med Clinic 8
C. Linden Med Clinic 3
D. POU 7

b. If records are not available from a certain program per month, totals from each program will be adjusted to reach a total of 20.

c. Inpatient charts for review will have a minimum length of stay of seven days.

d. POU charts will have a minimum length of stay of 36 hours.

e. PACT/Hearts charts will have a minimum length of stay of ninety days

f. Medication clinic clients will have been open to services and attended at least 4 appointments prior to discharge.

COMPLETION AND DELINQUENCY REVIEW

(Please refer to Policy NN-IM-MR-17 for complete outline of process.

A. Upon discharge from programs at NNAMHS, Health Information Services staff will prepare the record for closure, including an analysis of completeness of the record.

B. Reports entitled "Bi-weekly Staff Profile" and "Bi-weekly Medical staff profile" are completed.

1. This report outlines the number of incomplete or delinquent records by staff as well of a history of delinquent records per staff.

2. This report is forwarded to the Agency Director, Director of Nursing, Outpatient Medical Director, Medical Director, and Performance Improvement.

C. Each individual supervisor is expected to prompt the staff with the delinquent record to complete the record.

COMPLETION OF DOCUMENTATION AND TREATMENT PROCESS

A. A committee comprised of clinical staff including nurses, social workers, therapy staff and performance improvement will be appointed. If possible, a representative from each program will be appointed to the committee.

B. The committee membership will rotate on an annual basis to allow for exposure to documentation auditing and as a training process for clinical staff.

C. Health Information Services will send the list of discharged records for review to Performance Improvement (PI) staff.

D. PI staff will notify committee member of the records they are to review

E. Each committee member will complete a review of the record (s), as assigned, and document the review on the appropriate review document. No clinical staff memberwill be assigned to review their own record. Staff will be asked to complete the review within 10 days.

F. Upon completion, documentation of the reviews will be submitted to the Performance Improvement Department for compilation of data and trends.

Trends will be reported monthly in the Accrediation Leadership meeting.

G. If corrective actions are required, the appropriate manager will be responsible for determining and completing this action.